

1620-C - COST EFFECTIVENESS STUDY STANDARD

EFFECTIVE DATES: 02/14/96, 10/01/17

REVISION DATES: 10/01/04, 02/01/05, 09/01/05, 01/01/06, 07/01/06, 10/01/06, 10/01/07,
01/01/11, 02/01/11, 07/01/11, 04/01/12, 05/01/12, 03/01/13, 01/01/16,
07/20/17

I. PURPOSE

This Policy applies to ALTCS E/PD, DES/DDD Contractors, Fee-For-Service and Tribal ALTCS as delineated within this Policy. Where this Policy references Contractor requirements the provisions apply to ALTCS E/PD, DES/DDD and Tribal ALTCS unless otherwise specified. This Policy establishes standards for the cost effectiveness study regarding services provided under Title XIX.

II. DEFINITIONS

CONTRACTOR	Unless otherwise specified, means Contractors for ALTCS managed care members, Tribal Contractors for ALTCS Fee-For-Service (FFS) members and the Targeted Case Management Contractor for acute care members with developmental disabilities. a. Tribal case management for on-reservation FFS members may be provided by the Tribal government through an Inter-Governmental Agreement (IGA) with AHCCCS or, if there is no IGA between AHCCCS and a Tribal government, case management is provided through a special Tribal case management Contractor. b. Contractors and the Targeted Case Management Contractor have formal contracts with AHCCCS.
HOME AND COMMUNITY BASED SERVICES	As defined in A.R.S. §36-2931 and §36.2939.

III. POLICY

- A. Services provided under Title XIX must be cost effective whether the placement is in an institutional facility or a Home and Community Based (HCB) setting. Placement in a HCB setting is considered appropriate if the cost of Home and Community Based Services (HCBS) for a specific member does not exceed 100% of the net cost of institutional care for that member, is the least restrictive setting and HCBS will meet the member's needs.

1. A Cost Effectiveness Study (CES) must be completed for all Arizona Long Term Care System (ALTCS) members who are Elderly and/or have a Physical Disability (E/PD) in a HCB setting and for those E/PD members currently placed in an institutional setting who have discharge potential according to the timeframes outlined in Exhibit 1620-1.
2. The Contractor's Annual Case Management Plan must describe a process used by the Contractor that evaluates the net cost of institutional care that meets the requirements of this policy. This process must include:
 - a. Calculation on institutional costs stratified for levels of care and specialized needs,
 - b. Annual re-assessment and adjustment of the institutional rates based upon changes in costs associated with the assessed levels of care and specialized needs, and
 - c. Implementation of processes consistent with this policy, for determination and evaluation of CES for each member and processes for resolution of cases where the net HCBS cost exceeds the net cost of institutional care.
3. A CES must be completed for members with developmental disabilities under the following circumstances:
 - a. Every three months for a member whose service costs exceed 80% of the cost of the appropriate institutional setting for the member,
 - b. When the service costs of a member whose service costs previously exceeded 80% of the cost of the appropriate institutional setting are subsequently reduced to below 80%, and/or
 - c. When discharge is contemplated for any member residing in an Intermediate Care Facility (ICF).
4. The net cost of institutional care for each member takes into consideration the specific member's assessed Level of Care, the institutional rate appropriate for that Level of Care and the amount of the specific member's "CES Share of Cost."
 - a. If the member has needs that would necessitate a specialized rate in an institutional setting (for example, Alzheimer's or behavioral unit, residential treatment center, extensive respiratory care), this cost must be used in calculating the cost effectiveness of HCBS,
 - b. The "CES Share of Cost" is the amount the Division of Member Services/ Arizona Long Term Care System (DMS/ALTCS) eligibility has determined, based on the member's income and expenses, that s/he would have to pay monthly **IF** s/he was placed in a nursing home,
 - c. The net Medicaid cost of institutional care is calculated by subtracting the monthly CES Share of Cost amount for the member from the monthly nursing facility cost based on the specific member's level of care or other needs. The result is called the Net Institutional Cost,
 - d. If the member has been assessed by the DMS/ALTCS unit, to have an actual Share of Cost that must be paid in HCBS, that amount is deducted from the total monthly cost of the HCB services the member needs. The result is called the "Net HCBS Cost",

- e. If the Net HCBS Cost is more than the Net Institutional Cost, then home care services at that level are not “cost effective” and cannot be provided unless the HCBS costs are expected to decrease to less than the cost of institutional care within six months of the current CES date. At that time, the member must be issued a Notice of Action (NOA) that explains any decision to not provide services at the level requested/needed by the member/representative and given an opportunity to file an appeal if s/he does not agree with the decision, and
- f. The portion of HCB services that are cost effective can be provided if the member/representative still desires HCBS placement and is willing to accept that level of services and to assume the potential risks of remaining at home without all the care that has been assessed as needed. The case manager must complete a managed risk agreement with the member/representative to document this situation,

Example of CES>100%

Total Nursing Home Cost		\$4920.10
CES Share of Cost	–	\$726.90
Net Institutional Cost	=	\$4193.20
SERVICES MEMBER NEEDS		
40 hours of Attendant Care per week		\$2924.00
12 Nursing visits per month	+	\$1341.60
Net HCBS Cost	=	\$4265.60
\$4265.60 DIVIDED BY \$4193.20 = 102%		
REQUESTED HCB SERVICES ARE NOT COST EFFECTIVE		

- g. If the member in the previous example requested all the services that could cost effectively be provided, the case manager should determine which services are priorities for the member and recalculate the CES, For example:

Total Nursing Home Cost		\$4920.10
CES Share of Cost	–	\$ 726.90
Net Institutional Cost	=	\$4193.20
SERVICES THAT CAN COST EFFECTIVELY BE PROVIDED		
40 hours of Attendant Care		\$2924.00
11 Nursing visits per month	+	\$1144.00
Net Home Services Cost	=	\$4068.00
\$4068.00 DIVIDED BY \$4193.20 = 97%		
REQUESTED HCB SERVICES ARE COST EFFECTIVE		

- h. Existing HCBS units cannot be reduced if there is an increased cost of services incurred to fill a service gap (for example, if personal care and homemaker services are provided to substitute for a gap in attendant care services).

5. When the cost of HCBS exceeds 80% of the cost of institutional care:

- a. Contractor case managers must provide written justification of services to their administration for approval, and
 - b. Tribal Contractor case managers must provide written justification of services to the AHCCCS Division of Fee-for-Service Management (DFSM) as a request for approval.
6. When the cost of HCBS exceeds 100% of the cost of institutional care, but the cost is expected to drop below 100% within the next six months because of an anticipated change in the member's needs:
 - a. A Contractor's administration may approve the HCBS costs. Justification and the approval must be documented in the case file, and
 - b. Tribal Contractor case managers must provide written justification of services to the DFSM Unit as a request for approval.
7. If the cost of HCBS is expected to exceed 100% of net institutional cost for more than six months the case manager must advise the member of the cost effectiveness limitations of the program and discuss other options.
 - a. The case manager must either reduce or not initiate any Title XIX service costs in excess of 100%. Contractors may review individual cases with the appropriate AHCCCS unit (DHCM or DFSM) before the decision to deny or reduce services is made. A NOA must be issued to the member regarding any decision to deny, reduce, limit or terminate requested services,
 - b. If the member chooses to remain in his/her own home even though the Contractor cannot provide all of the services which have been assessed as medically necessary (including those ordered by the member's Primary Care Provider [PCP]), a managed risk agreement/contract should be written. This agreement should document the services the Contractor can cost effectively provide, the placement/service options offered to the member, the member's choices with regard to those options, the risks associated with potential gaps in service and any plans the member has to address those risks (for example, volunteer services or paying privately for services). The member/guardian/designated representative's signature on the agreement documents his/her acknowledgement of the service limitations and risks,
 - c. The cost of HCBS services that will be retroactively approved during prior period coverage enrollment cannot exceed 100% of the cost of institutionalization for that member, and
 - d. The CES must be updated when there is a change in placement to HCBS or there is a change in services that would potentially place the member's costs at greater than 80% of institutional cost.
8. A CES may be completed indicating "NONE" for HCBS services needed under the following circumstances:
 - a. Members residing in nursing facility who have no potential for HCBS placement (Placement/Reason code: Q/05). Documentation in the member's case notes is required to justify the lack of discharge potential and that the nursing facility is the most appropriate placement,
 - b. Members receiving hospice services only (Placement/Reason code: 10).

Members receiving other Long Term Care (LTC) services in combination with hospice must have a CES completed in accordance with other CES policy explained in this section,

- c. Members residing in a nursing facility because the cost of HCBS would exceed 100% of institutional costs (Placement/Reason code: Q/01), or
 - d. Members with Acute Care Only status (Placement/Reason code: D/04, D/11 or D/12).
9. CES data must be entered into the Client Assessment Tracking System (CATS) system within 10 business days of the date the action took place (for example, initial on-site visit to determine service needs, placement changes or significant increase in cost of services). Refer to the Tutorial Guide for Pre-Paid Medical Management Information Systems Interface for ALTCS Case Management on the AHCCCS website, for information on the codes and procedures for entering CES data into the CATS system (CA160 screen).
- a. If the initial CES entered in the CATS system also reflects the assessment of the cost effectiveness of HCBS services provided in the PPC, a comment to that effect must be added to the case file or system notes if comments are entered in CATS. If the services entered on the initial CES do not reflect those provided during the PPC, a separate hard copy CES must be completed to demonstrate that PPC services were cost effective and this CES must be maintained in the case file.

Refer to the Tutorial Guide for Pre-Paid Medical Management Information Systems Interface for ALTCS Case Management on the AHCCCS website, for information on the codes and procedures for entering CES data into the CATS system (CA160 screen).

10. HCBS which must be included in the CES include:
- a. Adult day health,
 - b. Attendant care if the member chooses to utilize his or her spouse as the paid caregiver for these services, the spouse shall not be authorized for more than 40 hours of services in a seven day period. Refer to AMPM Policy 1240 for more information on this limitation,
 - c. Habilitation,
 - d. Home health nurse,
 - e. Home health aide,
 - f. Home delivered meals,
 - g. Homemaker services,
 - h. Personal care,
 - i. Respite, if provided in a repeated pattern, such as weekly,
 - j. Regularly scheduled medically necessary transportation when the round trip mileage exceeds 100 miles. These costs do not need to be included if similar costs would be incurred while in a nursing facility. For example, if dialysis transportation costs for an HCBS member would be essentially the same as if the member were in an institutional setting, these costs would not be included on the CES,
 - k. Emergency alert systems,

- l. Non-customized Durable Medical Equipment (DME) included in the nursing facility per diem and having a value exceeding \$300, regardless of purchase or rental (for example, standard wheelchairs, walkers, hospital beds). DME items covered under other insurance may be omitted from the CES until the Contractor assumes responsibility for partial or full payment,
 - m. Partial care (supervised, therapeutic and medical day programs),
 - n. Behavioral management (behavioral health personal assistance, family support and peer support),
 - o. Psychosocial rehabilitation (living skills training, health promotion, pre-job training, education and development, job coaching and employment support),
 - p. Assisted living facilities, and
 - q. Behavioral health alternative residential settings.
11. Services which are not to be included in a CES include:
 - a. Hospice services,
 - b. Customized DME items,
 - c. Physical, speech, occupational and/or respiratory therapies,
 - d. Medical supplies and pharmaceuticals,
 - e. Behavioral health services which are not listed above,
 - f. Home modification,
 - g. Community Transition Services, and
 - h. Member and/or DCW Training, authorized as part of a member directed service option.
12. If the member only receives ALTCS-covered HCBS that are provided by another funding source (Medicare, Children's Rehabilitative Services, tribal entities), s/he may still be in an HCBS placement and therefore must have a CES completed. The CES should be completed indicating the services received, but with no unit cost paid by the Contractor.